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Reinhardt's Last Book, a Book Review by David Henderson of Priced Out: The Economic and Ethical Costs of American Health Care by Uwe Reinhardt

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writes Cowen, "would have astonished us as recently as the 1980s." He understates the case; it would have astonished us as recently as the late 1990s or even the early 2000s.

What about the fake news stories published on Facebook during the 2016 election? Cowen notes how trivial they were as a percentage of user actions and points out that the "more serious" mainstream media sources ran many stories about candidate Hillary Clinton's email scandal. He quotes a *Columbia Journalism Review* estimate that, over six days during the campaign, the *New York Times* "ran as many front-page stories about Clinton's emails as it did about all policy issues over the sixty-nine days immediately preceding the election." As far as I know, President Trump has not thanked the *Times*, but he should.

Moreover, if the electronic media bear most of the blame for the dreck that they publish, how should we think about brick-and-mortar publishers? Cowen notes that for-profit publishers have printed the works of Marx, Mao, Hitler, and Stalin. Those four, indirectly in Marx's case and directly for the other three, were responsible for over 100 million deaths in the 20th century. Great line: "Facebook hasn't come anywhere near to doing the damage that the printing press (and radio) did by helping to communicate the ideas of fascism, Marxism, communism, and so on."

In that same chapter, Cowen reports on a debate he had with writer Nicholas Carr, who argues that Google makes us stupid. The first question that Cowen asked Carr was whether Carr had prepared for the debate by using Google to research him. Writes Cowen, "I thought I had won right then and there." Presumably Carr had to answer "Yes." From personal experience, I can say that even if Google hasn't made me smart, it has certainly made me more informed.

Toward the end of the chapter, Cowen does raise a justified concern that tech will cause us to lose our privacy. It's hard to know how to counter that loss.

One of the book's best chapters, which added to my stock of knowledge, is "What Is Wall Street Good for, Anyway?" It turns out to be a lot. Cowen's section on the importance of venture capital in the history of many major companies is eye-opening. It's also heartening to see that 55% of U.S. households own stock, up from 32% in 1989. Cowen also highlights Vanguard's positive role in bringing down fees paid to mutual fund companies. He reports that people who have invested with Vanguard have saved $175 billion by not paying the average active fund fee since 1974, when Vanguard began. It has also saved investors about $140 billion through lower trading costs. I had known that the savings were large, but I had not known that they were that large.

The biggest surprise, though, is that, as one partner in a Swiss law firm put it, "America is the new Switzerland." American laws, writes Cowen, have evolved to produce a high level of secrecy for some asset holders in this country. And South Dakota seems to be our own Luxembourg. With only 850,000 people, South Dakota "is home to more than $226 billion in assets held in trusts."

I've not even mentioned the last two chapters, "Crony Capitalism" and "If Business Is So Good, Why Is It So Disliked?" They're excellent also.

All in all, Cowen's love letter is sorely needed, not mainly by America's big businesses, but by America's voters. If 30% of the voters understood even 20% of the insights in this book, we would likely have much better policies and Americans, over time, would be much better off. *R*

Reinhardt's Last Book

REVIEW BY DAVID R. HENDERSON

Uwe Reinhardt was a well-known health economist at Princeton University who died in 2017. An outspoken advocate of government regulation of health insurance, he helped design the single-payer system adopted by Taiwan's government.

Reinhardt's last book is *Priced Out: The Economic and Ethical Costs of American Health Care*. In it, he argues that U.S. health care is too expensive, its administrative costs are too high, the U.S. tax system subsidizes health care for high-income people, and the government should increase the subsidy for health care for low-income people. He also expresses strong skepticism about requiring people to pay more out of pocket for their own health care, claiming it will not push consumers to price-shop for care.

Unfortunately, in the book Reinhardt biases his comparison of drug prices across countries and says nothing about the U.S. Food and Drug Administration's role in causing high drug prices. In claiming that people won't price-shop when their incentives are changed by higher deductibles, he uses one company's experiment to generalize to the whole country. Yet he himself, with his advocacy of reference pricing, argues that people who have to pay out of pocket *will* price shop. In discussing the tax treatment of employer-provided health insurance, he likens taking advantage of the tax break to feeding at the public trough. An immigrant himself—first from Germany to Canada, and then from Canada to the United States—Reinhardt criticizes the hiring of immigrant doctors. One refreshing proposal, though, is his idea for letting people avoid the Affordable Care Act (ACA) and take responsibility for their own health insurance.

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IN REVIEW

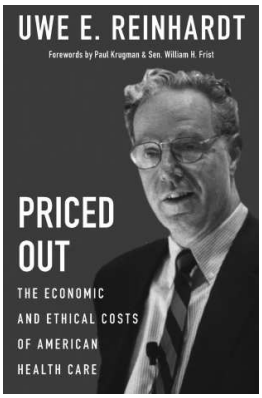
Drug prices / Reinhardt's most important factual message is that Americans spend more per capita on health care than people in any other country and that the prices we pay for health care are much higher than prices elsewhere. He is right on both counts.

He uses two figures, though, that bias the comparison for drug prices. One figure shows that the average price for a 30-day supply of Xarelto, used to prevent or treat blood clots, is $292 in the United States versus $126 in the United Kingdom and $48 in South Africa. Another figure shows that the average price for a 30-day supply of Tecfidera, used to treat multiple sclerosis, is $5,089 in the United States versus $1,855 in Switzerland and $663 in the UK. Those comparisons are biased because both drugs are brand-name drugs, yet a large percentage of the drugs Americans take are generics.

According to an October 2017 study by the Commonwealth Fund, 84% of the drugs Americans took in 2014 were generics. The UK percentage was also 84%, but every other country was much lower. The lowest in the Commonwealth Fund study was Switzerland, where only 22% of drugs taken were generics.

Not surprisingly, therefore, the differences in spending on drugs between the United States and these other countries were narrower than the brand-name drug prices would suggest. In 2015, according to the Commonwealth study, per-capita spending on pharmaceuticals in the United States was $1,011.40 versus $783.30 in Switzerland and $497.40 in the UK. One might wonder if that's because the higher prices in America give us an incentive to buy a lower quantity of drugs per person, but the Commonwealth study says that's not so: "Drug utilization appears to be similar in the U.S. and the nine other countries considered."

Disappointingly, in Reinhardt's discussion of drug prices he does not mention one of the culprits responsible. The FDA makes prices higher for some drugs by putting barriers in the way of pharmaceutical companies that make so-called "me-too" drugs. Frequent *Regulation* contributor Henry Miller of the Pacific Research Institute has defended such drugs on the grounds that no drug is a perfect substitute for another and that, therefore, some patients whom the original drug wouldn't help would benefit from the me-too drug. But there's also a narrow economic argument for these drugs, one that I'll make by analogy with cars: A Chevrolet is a me-too Ford. If a government agency put barriers in the way of Chevrolets, Fords would be more expensive. Putting barriers in the way of me-too drugs gives pharmaceutical companies even more market power.



Priced Out: The Economic and Ethical Costs of American Health Care

By Uwe E. Reinhardt

201 pp.; Princeton University Press, 2019

Cost-sharing / Many health economists, including me, have proposed reining in wasteful health care spending in the United States by moving to catastrophic health insurance. Under this, people would pay out of pocket for the first few thousand dollars of each year's health-care spending. That change, many of us have argued, would encourage patients to be more cost conscious, shopping around for cheaper drugs, asking tougher questions of doctors who want to order expensive tests, maybe even choosing hospitals for non-emergency surgery based on costs, and, of course, cutting out less-important care.

We do have evidence of this happening. In the famous RAND health insurance experiment that ran from November 1974 to January 1982, thousands of people were given health insurance with wide variation in co-insurance rates—the percentage of medical bills paid by the participants in the experiment. The co-insurance rate varied from 0% to 95%. The experiment found that patients faced with higher co-insurance rates used less medical care, yet there was little effect on health outcomes. This suggests that people who had to pay more out of their own pockets cut out the least beneficial medical care.

Reinhardt doesn't mention the RAND experiment, but he calls the idea of shopping for cost-effective health care "a cruel hoax." He writes, "Patients typically do not know binding prices and robust data on the quality of care when they approach the health care system." He writes further, "In effect, they enter that market like blindfolded shoppers pushed into a department store." He cites a 2015 National Bureau of Economic Research study that found that a large company that had switched to high deductibles did find health care spending by its employees fell by 11.8–13.8%, which is significant. But, the researchers also found, this reduction was due entirely to a reduction in the quantity of health care purchased; having patients be responsible for more of the cost of their health care did not cause any increase in actual price shopping.

There's an explanation for this finding that confounds Reinhardt's argument. Even the employees of a large company are just a tiny percentage of the market. So, providers, used to figuring out the prices of health care only *after* the care is provided, are not set up to give price information in advance to those who ask. That likely would change if high deductibles became more common.

The best way to see whether higher out-of-pocket costs cause people to price-shop for health care is to examine a market in which a large percentage of patients pay for their own care. One such market is for LASIK eye surgery. A quick Google search finds that prices, though not quoted to the penny, are customarily prominently displayed on LASIK surgeons' websites, which also often offer financing options. Why mention prices if people are not price shopping? Interestingly, after stating, "Most prices for health care in the United States are kept as trade secrets between insurers and providers of care,"

Reinhardt admits the point about LASIK, writing, "The only exceptions are said to occur in the markets for LASIK and cosmetic surgery, where physicians usually do apprise patients of prices ahead of the treatment." It does seem, therefore, that if a large percentage of Americans had high deductibles, a substantial portion of these consumers would price-shop much more than they do now.

Surprises / In his discussion of high costs, Reinhardt points out the awful reality that patients often get "surprise" medical bills. They can carefully choose a hospital within their insurer's network, but learn only too late that various doctors on their case were "out of network." The result: surprise medical bills that can run into the thousands of dollars. One partial solution for this would be for the government to allow more vertical integration in health care so that all of the providers for a given surgery would be in the same firm and thus part of its insurance network. One barrier to vertical integration is Certificate of Need (CON) regulations that many states have: these laws make it difficult for competitors to start hospitals and surgery centers. Unfortunately, Reinhardt doesn't mention CON regulations.

While on the subject of surprises, I'll note one I had in reading the book's epilogue by Reinhardt's widow, Tsung-Mei Cheng, a health policy research analyst at Princeton's Woodrow Wilson School of Public and International Affairs. She quotes Reinhardt's statement in 2009, before Congress passed the ACA, that America should use "reference pricing." She also quotes from his lengthy 2009 C-SPAN interview in which he explained the idea. Insurance companies would pay 100% of the price of a low-cost drug or a low-cost hospital visit, which would be the "reference price." But if some patients want a more expensive drug or hospital, they would have to pay the difference between the price of that care and the reference price. That would give patients good incentives: their health care basics would be covered and they would decide whether the extra quality or luxury was worthwhile. This seems like a good idea, but it surprised me that Reinhardt embraced it because it sounds awfully close to the notion of price shopping that he rejected in the book.

One policy that would likely move insurance companies closer to reference pricing is to reform the tax treatment of employers' contributions to their employees' health insurance. The contribution is a legitimate cost of doing business and, therefore, for tax purposes is deductible from the employers' revenue. But it's tax-free income to the employee. That gives employers an incentive to provide more-generous health insurance than otherwise.

Reinhardt highlights this fact, but he calls the tax treatment a "generous public subsidy." The people taking advantage of it, he writes, have "their paws so squarely in the public trough." He's mistaken. It's true that in its economic effects, the tax-free treatment of employers' contributions *acts like* a subsidy. But it's not a subsidy; it's a way for employees to reduce their tax bill. While the tax treatment does create bad incentives, it is no more a subsidy than a tax rate cut would be. Reinhardt's implicit assumption is that the government owns the employees' income.

His language on another issue, immigration of doctors, is also disturbing. In the aforementioned C-SPAN interview, he stated that when doctors who have trained in other countries move to the United States, we are "robbing them of their physicians." We're not. When Reinhardt and I moved to the United States from Canada, the United States did not "rob" Canada of budding economists; we immigrated. The case with doctors is no different.

In her epilogue, Cheng points out that when Reinhardt was a child in Germany, he and his siblings had health care through the "social insurance" system that Chancellor Otto von Bismarck established back in 1883. She comments, "Germans may not always have had enough food in those years, but all had the health care they needed." That comment is telling. There are tradeoffs. Would you rather spend a dollar on health care or on food, and who should get to choose? Cheng's comment implies, and presumably her husband would have agreed, that it should be the government's choice and the government should choose health care over food. Why that's so is unclear. Elsewhere in the book, Reinhardt notes that health care contributes "no more than 10 percent to 20 percent of observed cross-country variations" in health status measures. For some people, especially poor people, food could easily be more important than health care.

Community rating proposal / I'll end with a Reinhardt policy idea I like, about how government should deal with a perverse incentive that the ACA creates. The ACA requires insurers that sell individual health insurance policies to practice community rating. "Community rating" means that insurance companies charge the same premium to healthy people that they charge to unhealthy people. The result, he notes, is that a high percentage of healthy people will game the system, refraining from buying insurance until they are sick.

The usual solution for this that health policy analysts advocate is to require the uninsured to wait months or years before they can buy community-rated insurance. Reinhardt takes this idea a step further. He would require all American residents, at age 26, to buy community-rated insurance. If they refuse, they would not be allowed to buy community-rated insurance at any time in the future. They would instead go uninsured or buy insurance priced according to risk.

As long as government would not regulate the items that individual insurance would cover, this strikes me as a good proposal. I could imagine young people saving a few thousand dollars a year and then, when they get sick at, say, age 50, having tens of thousands of dollars to spend on health care. I could also imagine them doing what my daughter did before the ACA prohibited it: buy risk-priced health insurance with guaranteed renewability. That would be a large improvement on the current system. *R*